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LOW-INCOME AND MINORITY BENEFICIARIES DO *NOT* RELY DISPROPORTIONATELY ON MEDICARE ADVANTAGE PLANS

Industry Campaign to Protect Billions in Overpayments Rests on Distortions

By Edwin Park and Robert Greenstein

The Medicare Payment Advisory Commission (MedPAC), Congress' expert advisory body on Medicare payments, reported this month that Medicare is losing billions of dollars each year because of excessive payments to private insurance plans through the Medicare Advantage program. (Under that program, Medicare beneficiaries may elect coverage through private "Medicare Advantage" plans rather than through traditional fee-for-service Medicare.) Although private plans ostensibly were brought into Medicare to introduce competition and reduce costs, MedPAC has found that, on average, the federal government is paying the private plans *12 percent more* than it costs to treat comparable beneficiaries through traditional Medicare.¹

In testimony before Congress on March 1, MedPAC chairman Glenn Hackbarth warned that these overpayments are driving up Medicare costs substantially and making the task of sustaining Medicare more difficult. Hackbarth stated that Medicare faces "a very clear and imminent risk from this overpayment that will put this country in an untenable position."²

KEY FINDINGS

- Private "Medicare Advantage" health plans were brought into Medicare to reduce costs, but Medicare pays them *12 percent more* than the cost of treating comparable beneficiaries through traditional Medicare, adding billions to Medicare's costs.
- Private plans argue that curbing the overpayments would harm low-income and minority Medicare beneficiaries, who they claim rely disproportionately on Medicare Advantage for supplemental coverage. This claim, however, is based on misleading use of data.
- Medicaid, not Medicare Advantage, is the main form of supplemental coverage for low-income and minority Medicare beneficiaries. The most cost-effective way to help these individuals would be to strengthen the programs within Medicaid on which many of them rely to supplement Medicare coverage and to pay the Medicare premiums for them.
- Moreover, the overpayments are *harming* millions of minority beneficiaries by raising their monthly Medicare premiums. The overpayments also are weakening Medicare's finances and ballooning its costs, thereby building pressure for sizable Medicare cuts in the future.
- Curbing overpayments to Medicare Advantage plans would benefit Medicare beneficiaries by reducing costs and premiums and improving Medicare's long-term fiscal sustainability.

¹ See Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2007.

² BNA's Health Care Daily Report, "Growth of Managed Care Plans Threatens Program's Finances, MedPAC Chairman Says," March 2, 2007.

MedPAC has called on Congress to rein in the excessive payments to private plans and has recommended several specific reforms. The Congressional Budget Office (CBO) estimates that the largest of these reforms — MedPAC’s proposal to “level the playing field” by adjusting the payment formula so private plans essentially are paid the same amounts it would cost to treat the same patients under regular Medicare — would save *\$65 billion* over five years and *\$160 billion* over ten years.³ Other MedPAC recommendations to address excessive Medicare payments to private plans would save tens of billions of dollars more.

In response, the private plans have launched a campaign contending that curbing the overpayments would harm low-income and minority Medicare beneficiaries. The plans claim that these beneficiaries rely disproportionately on private plans for “supplemental coverage” — that is, for help in paying Medicare premiums and cost-sharing and for some supplemental benefits not covered by traditional Medicare fee-for-service.⁴ The plans and their defenders cite a recent analysis issued by America’s Health Insurance Plans (AHIP), the powerful trade association and lobby for private insurance companies, that analyzes 2004 data from the Medicare Current Beneficiary Survey.⁵ They present these data as showing that low-income and minority beneficiaries benefit disproportionately from the coverage that the private plans offer.

Some members of Congress who support the private plans already have begun to echo these arguments.⁶ In addition, AHIP has indicated that it intends to use its clout to generate efforts in minority communities to oppose reining in the overpayments.⁷

A careful analysis of AHIP’s own data reveals, however, that AHIP’s claims are based on a selective, and distorted, culling of the data, as explained below.

It should also be noted that the overpayments are harming millions of beneficiaries — including minority beneficiaries — by raising the Medicare premiums they pay each month. These premiums must be set at a higher level than would otherwise be the case in order to help cover the costs of the overpayments. Moreover, the overpayments threaten to harm beneficiaries more in coming years; by driving up Medicare costs, the overpayments are deepening Medicare’s looming financing shortfalls and creating a need for deeper Medicare cuts (or larger tax increases) than would otherwise be required.

³ Specifically, MedPAC has recommended that the benchmarks used to assess the bids that private plans submit (and to determine payments to the plans) be set at 100 percent of local Medicare fee-for-service costs. See Congressional Budget Office, “Budget Options,” February 2007.

⁴ See, for example, America’s Health Insurance Plans, “AHIP Raises Concerns about New MedPAC Report and Its Potential Impact on Beneficiaries,” March 1, 2007.

⁵ America’s Health Insurance Plans (AHIP), “Low-Income and Minority Beneficiaries in Medicare Advantage Plans,” February 2007 (analyzing the Access to Care File). This report is similar in many respects to a prior analysis issued by the Blue Cross and Blue Shield Association. See Adam Atherly and Kenneth Thorpe, “Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries,” Blue Cross and Blue Shield Association, September 20, 2005.

⁶ BNA’s Health Care Daily Report, “Medicare Advantage ‘On the Table’ for Democrats Seeking Budget Savings,” March 7, 2007.

⁷ Karen Ignagni, President and CEO of AHIP, recently stated: “As members of Congress engage in budget discussions, they will be hearing from their low-income and minority constituents who count on the essential benefits and lower out-of-pocket costs Medicare health plans provide.” See Gregory Lopes, “Congress considers insurance plan cuts,” *Washington Times*, March 22, 2007.

Finally, as the last section of this analysis explains, there are more efficient and effective ways to assist low-income and minority beneficiaries than to continue showering billions of dollars of excessive payments on private plans so that a fraction of those payments may trickle down to these beneficiaries.

AHIP's own data show that more low-income and minority Medicare beneficiaries receive supplemental coverage through Medicaid than through private plans.

AHIP and others — including the Administration, as explained in the box on page 4⁸ — have implied that more low-income and minority Medicare beneficiaries obtain supplemental coverage from private plans than from any other source. This claim is untrue. (AHIP produces this claim by failing to include Medicaid and employer-based retiree coverage as options that provide supplemental coverage, which distorts the data.⁹)

- Nearly half (48 percent) of all Medicare beneficiaries with incomes below \$10,000 are enrolled in, and thus receive supplemental coverage through, Medicaid. This is *nearly five times* the proportion (10 percent) who are enrolled in Medicare Advantage plans. (Even the percentage of beneficiaries with incomes below \$10,000 who rely on *Medigap* coverage is slightly greater than the percentage enrolled in Medicare Advantage.)¹⁰

These figures are significant, since fully one-fifth of Medicare beneficiaries who live in areas with access to a Medicare Advantage plan have incomes below \$10,000.¹¹ So do 42 percent of all African American beneficiaries, half of Hispanic beneficiaries, and 42 percent of Asian American beneficiaries.¹²

- And indeed, minority Medicare beneficiaries, as well, are much more likely to receive supplemental coverage through Medicaid than through Medicare Advantage plans. Most Asian American Medicare beneficiaries (58 percent), and a plurality of African American (30 percent) and Hispanic beneficiaries (34 percent), receive supplemental coverage through Medicaid. By contrast, the percentages of minority beneficiaries who are enrolled in private plans — 14

⁸ See also, “The Facts: Medicare Advantage,” March 22, 2007 (co-authored by health analysts from the American Enterprise Institute, the Center for Medicine in the Public Interest, the Galen Institute, the Heritage Foundation, and the National Center for Policy Analysis, among others).

⁹ See, for example, AHIP, “Low-Income and Minority Beneficiaries in Medicare Advantage Plans” and Atherly and Thorpe, *op cit* (which both contend that among “active choosers,” more low-income and minority beneficiaries opt for Medicare Advantage than any other form of supplemental coverage. Their category of “active choosers”, however, excludes Medicare beneficiaries with access to Medicaid or employer-based retiree coverage).

¹⁰ See Table 3A in AHIP, *op cit*. Some 11 percent of beneficiaries below \$10,000 have Medgap coverage, while 10 percent are enrolled in Medicare Advantage plans. Looking just at those beneficiaries below \$10,000 who have some form of supplemental coverage (through Medicaid, employer-based retiree coverage, Medigap, other forms of public coverage, or Medicare Advantage), 61 percent relied on Medicaid, while 14 percent relied on Medigap, and 13 percent relied on Medicare Advantage.

¹¹ See Table 7A in AHIP, *op cit*. Among *all* Medicare beneficiaries, more than 20 percent have incomes below \$10,000. See, for example, Centers for Medicare and Medicaid Services, “Characteristics and Perceptions of the Medicare Population: Data from the 2003 Medicare Current Beneficiary Survey”, 2003 (finding that 22 percent of all Medicare beneficiaries had incomes below \$10,000).

¹² In contrast, only 16 percent of white Medicare beneficiaries had incomes below \$10,000. See Table 1A in AHIP, *op cit*.

Administration Assertions Likewise Rest on Misleading Use of Data

Like AHIP, Administration officials have claimed that Medicare Advantage plans enroll a disproportionate number of low-income and minority Medicare beneficiaries. They have implied that these plans are the principal form of supplemental coverage for such beneficiaries and argue that curbing overpayments to the plans would adversely affect these populations. The figures on which the Administration bases these claims, however, are highly problematic:

- Leslie Norwalk, acting administrator of the Centers for Medicare and Medicaid Services, recently stated that 57 percent of Medicare Advantage enrollees have incomes between \$10,000 and \$30,000, as compared to 46 percent of fee-for-service beneficiaries.* These figures, however, exclude all beneficiaries with incomes *below \$10,000*, a group that constitutes fully one-fifth of all Medicare beneficiaries and a much larger share of African American (42 percent) and Hispanic (50 percent) beneficiaries. The reason for this omission seems clear: as the AHIP data show, these very low-income Medicare beneficiaries are overwhelmingly enrolled in fee-for-service and rely on Medicaid, not Medicare Advantage, for supplemental coverage. Indeed, other analysis shows that while 22 percent of fee-for-service beneficiaries are in the under \$10,000 income category, only 14 percent of Medicare Advantage beneficiaries are.**
- Similarly, half of all Medicare beneficiaries and much larger percentages of minority beneficiaries have incomes *below \$20,000*. The percentage of fee-for-service beneficiaries who are in this income category exceeds the percentage of Medicare Advantage enrollees who are in this income group. (The Administration notes that about 49 percent of Medicare Advantage enrollees have incomes below \$20,000, but generally fails to point out that 51 percent of fee-for-service beneficiaries do.)**
- In short, while the Administration and AHIP seek to portray Medicare Advantage as having more of a low-moderate-income enrollee character than Medicare fee-for-service, such a portrayal is not accurate.
- In seeking to present private plans as the principal form of supplemental coverage for minority beneficiaries, the Administration (and AHIP) conveniently (and inappropriately) omit Medicaid as a form of supplemental care.*** This suits their purposes. Some 69 percent of Medicare minority beneficiaries with incomes below \$10,000 are enrolled in Medicaid, while only 9 percent are enrolled in Medicare Advantage.** Minorities comprise as much as 45 percent of Medicare beneficiaries who also receive Medicaid.**** (The Administration also claims that overall, minorities make up a larger share of Medicare Advantage enrollees than of fee-for-service enrollees.* Even if this claim is valid — and it conflicts with the AHIP data — it is clear that minority Medicare beneficiaries who are low-income overwhelmingly remain in traditional fee-for-service and primarily rely on Medicaid, not Medicare Advantage, for their supplemental coverage.)

* See Leslie Norwalk, Testimony before the Subcommittee on Health of the House Ways and Means Committee, March 21, 2007 (relying on 2005 data from the Medicare Current Beneficiary Survey, which are not yet publicly available).

** Kaiser Family Foundation analysis of 2003 Medicare Current Beneficiary Survey (Cost and Use File).

*** Centers for Medicare and Medicaid Services, “Medicare Advantage in 2007,” March 2007 (finding that only 12 percent of fee-for-service enrollees with supplemental coverage are minorities, as compared to 27 percent of Medicare Advantage enrollees).

**** Centers for Medicare and Medicaid Services, Centers for Medicare and Medicaid Services, “Characteristics and Perceptions of the Medicare Population: Data from the 2003 Medicare Current Beneficiary Survey”, 2003.

percent of Asian Americans, 13 percent of African Americans, and 25 percent of Hispanics — are considerably smaller.¹³

¹³ See Table 5A in AHIP, *op cit*. Looking just at those minority beneficiaries who have supplemental coverage: 75 percent of such Asian American beneficiaries were enrolled in Medicaid, as compared to 15 percent in Medicare

- The picture is similar among Medicare beneficiaries with incomes below \$20,000, a category that includes nearly half of Medicare beneficiaries with access to a private plan — and the overwhelming bulk of minority beneficiaries.¹⁴ (Some 72 percent of African American beneficiaries, 81 percent of Hispanic beneficiaries, and 79 percent of Asian American beneficiaries have incomes below \$20,000.)

Among beneficiaries with incomes below \$20,000 who live in an area where a Medicare Advantage plan is available, a larger share receive supplemental coverage through Medicaid than through a Medicare Advantage plan.¹⁵

AHIP's data show that low-income and minority beneficiaries enroll in Medicare Advantage plans to a lesser — not a greater — degree than other Medicare beneficiaries.

- Beneficiaries with incomes of less than \$10,000 constitute 20 percent of all beneficiaries who live in areas with access to a Medicare Advantage plan but just 16 percent of Medicare Advantage enrollees.¹⁶
- Similarly, African Americans represent 11 percent of all beneficiaries who live in areas with access to a Medicare Advantage plan but 10 percent of Medicare Advantage enrollees. They constitute a much larger share — 22 percent — of the Medicare beneficiaries who also receive Medicaid, as well as 18 percent of the Medicare beneficiaries who rely on other forms of public coverage, including military or veteran's health care. It is these other forms of supplemental coverage, not private plans, that African American beneficiaries make disproportionate use of.
- Asian Americans constitute 2 percent of all beneficiaries with access to a Medicare Advantage plan but 1 percent of Medicare Advantage enrollees.
- Hispanics are slightly more likely to enroll in Medicare Advantage; they constitute 3 percent of all beneficiaries with access to a Medicare Advantage plan and 4 percent of Medicare Advantage enrollees.¹⁷ This likely reflects where Hispanic beneficiaries live. States like California and

Advantage; 44 percent of such Hispanic beneficiaries were enrolled in Medicaid, as compared to 32 percent in Medicare Advantage; and 39 percent of such African American beneficiaries were enrolled in Medicaid, as compared to 17 percent in Medicare Advantage.

¹⁴ See Table 1A in AHIP, *op cit*.

¹⁵ CBPP analysis of Table 4A and 7A in AHIP, *op cit*.

¹⁶ See Table 7A in AHIP, *op cit*. As one would expect, beneficiaries with incomes below \$10,000 account for 69 percent of Medicare beneficiaries who also receive Medicaid.

One also can look at beneficiaries with incomes between \$10,000 and \$20,000. They constitute 27 percent of Medicare beneficiaries who live in areas with access to a Medicare Advantage plan. While they account for 33 percent of the Medicare Advantage enrollees, they also constitute 56 percent of individuals with other forms of public coverage (such as military or veteran's health care), 29 percent of beneficiaries with Medigap coverage, and 28 percent of beneficiaries who also are enrolled in Medicaid.

¹⁷ See Table 8A in AHIP, *op cit*. AHIP emphasizes that 68 percent of minorities enrolled in Medicare Advantage plans have incomes below \$20,000. Its own data show, however, that among all minority Medicare beneficiaries who live in

Florida, which have large Hispanic populations, have traditionally had higher managed-care penetration rates than other states, both in Medicare and in employer-based insurance.

It is important to recognize that Medicare Advantage enrollment has risen substantially since 2004, the year on which these data are based. The increase has principally occurred among private fee-for-service plans that concentrate in rural and suburban areas (see box on page 10).¹⁸ As a result, minorities likely make up an even smaller proportion of Medicare Advantage enrollees today than the figures cited here.

Overpayments Harm Millions of Beneficiaries and Increase Risks of Future Cutbacks

The private plans use a portion of the Medicare overpayments they receive to reduce Medicare premiums or cost-sharing charges, as well as to provide some health benefits that Medicare otherwise does not cover. In essence, the current system funnels tens of billions of dollars in excess reimbursements to the private plans, a portion of which are used to provide some additional benefits that entice enrollees to switch from regular Medicare to the private plans.¹⁹ This approach harms the million of beneficiaries who are *not* enrolled in the private plans, including millions of minority beneficiaries. It also is fundamentally inequitable:

- Since the monthly premiums that Medicare beneficiaries pay are based on Medicare costs — and the overpayments drive up those costs — the overpayments raise the premiums that beneficiaries must pay. As a result, beneficiaries in Medicare fee-for-service are forced to pay higher premiums to subsidize the excess payments being made to the private plans, even though these beneficiaries receive no extra coverage in return.²⁰ This reduces the disposable income that tens of millions of seniors and people with disabilities have to live on, including large numbers of minority beneficiaries.

Furthermore, as enrollment in Medicare Advantage continues to rise, the total amount of overpayments made to the private plans grows as well (Medicare overpaid an average of \$922 for each Medicare Advantage enrollee in 2005.²¹) This drives up Medicare premiums further. As a result, if the overpayments are not reined in, beneficiaries will face additional premium increases — to cover a larger volume of overpayments — in the years ahead.

- Under the current arrangements, beneficiaries who do not have access to Medicaid, retiree

areas with access to a Medicare Advantage plan, approximately 78 percent have incomes below \$20,000. AHP generally does not include that point in its presentations. CBPP analysis of Table 2A in AHIP, *op cit*.

¹⁸ See, for example, Peter Orszag, “The Medicare Advantage Program: Trends and Options,” Testimony before the Subcommittee on Health of the House Ways and Means Committee, Congressional Budget Office, March 21, 2007.

¹⁹ In some cases, Medicare beneficiaries in poorer health who use more health care services may actually incur higher out-of-pocket costs in their Medicare Advantage plans than in traditional fee-for-service. See Brian Biles, Lauren Nicholas, and Stuart Guterman, “Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?” The Commonwealth Fund, May 2006.

²⁰ Mark Miller, “Medicare Advantage Program and MedPAC Recommendations,” Testimony before the Subcommittee on Health, House Ways and Means Committee, Medicare Payment Advisory Commission, March 21, 2007.

²¹ Brian Biles *et al.*, “The Cost of Privatization: Extra Payments to Medicare Advantage Plans — Updated and Revised,” The Commonwealth Fund, November 2006.

MedPAC's Goals Regarding Private Plans

Mark Miller, MedPAC's executive director, recently testified that one of MedPAC's goals is to ensure that Medicare dollars are spent wisely, "ensuring that beneficiaries are getting efficient, high-quality care, and that beneficiaries and taxpayers are getting maximum value for each dollar spent in the program."

Miller noted that "Medicare's private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Efficient plans could be able to provide extra benefits to enrollees choosing to enroll in such plans, and better efficiency would lead to higher plan enrollment." Miller explained, however, that MedPAC has found that Medicare Advantage "has instead become a program in which there are few incentives for efficiency," due to its payment structure and the high volume of excessive payments made to the private plans. As a result, "all taxpayers, all Medicare beneficiaries — not just the 18 percent of beneficiaries enrolled in private plans — are funding the payments in excess of" Medicare fee-for-service costs.*

To address these problems, MedPAC has recommended that Medicare private plans be paid at the same levels as it would cost to treat comparable participants in regular Medicare fee-for-service. MedPAC has consistently emphasized that it supports competition between Medicare fee-for-service and private plans and is *not* calling for elimination of the private plans. It simply is recommending a level playing field, or a foundation of "financial neutrality," where Medicare fee-for-service and Medicare Advantage compete fairly.

* Mark Miller, "Medicare Advantage Program and MedPAC Recommendations," Testimony before the Subcommittee on Health, House Ways and Means Committee, Medicare Payment Advisory Commission, March 21, 2007.

coverage, Medigap, or other public coverage can obtain reduced cost-sharing or supplemental benefits *only* if they switch from traditional Medicare fee-for-service to Medicare Advantage and consequently become subject (in many cases) to substantial restrictions in their choice of providers. Most private plans in Medicare Advantage, such as HMOs, impose such restrictions.

- The overpayments also pose other risks to beneficiaries. As MedPAC chairman Glenn Hackbarth has warned, the overpayments weaken Medicare's finances and threaten the federal government's ability to sustain Medicare over time. If the overpayments are not curbed, they will contribute to ballooning Medicare costs and to growing pressures to cut Medicare. Such cuts could entail increased out-of-pocket costs and reduced benefits for Medicare beneficiaries. Cuts of this nature could be particularly deleterious to low-income and minority beneficiaries, who can least afford to pay larger amounts for health care out of their own pockets.

Much Better Ways Exist to Help Low-Income and Minority Beneficiaries

The private plans have responded that if the overpayments are curbed, plans may withdraw from Medicare Advantage, which would have adverse consequences for the low-income and minority Medicare beneficiaries enrolled in these plans. To be sure, CBO estimates that enactment of the MedPAC recommendation to level the playing field — i.e., to set payments to private plans at the same levels as it costs to treat comparable patients in Medicare fee-for-service — would lead to about 1.8 million fewer Medicare beneficiaries being enrolled in private plans by 2012 than are enrolled today. (These beneficiaries would enroll in the regular Medicare program instead.) This

Other Expert Commentary on Overpayments to Private Plans and Risks They Pose

Leading Medicare expert Dr. Robert Berenson of the Urban Institute, who previously oversaw Medicare payment policy at the Health Care Financing Administration (since renamed the Centers for Medicare and Medicaid Services), recently wrote that changes contained in the 2003 prescription drug law have significantly increased the excessive Medicare payments being made to private plans. In essence, Berenson observed, the law is “throwing money at the private insurers.” So instead of *saving* money (private plans were originally designed to be paid 5 percent less than the cost of fee-for-service in order to reward their expected efficiency), “taxpayers are now paying *12 percent more* per beneficiary to the private plans. That means the government is paying private insurers about \$1,000 more per enrollee than it would cost to keep the beneficiary in the traditional plan — all in order to help the private plans entice healthy seniors away from traditional Medicare” (emphasis added).

The end result, Berenson warns, may be to undermine Medicare over time and lead to large-scale privatization of the program. Berenson cites a Goldman Sachs report that concludes “...[Medicare Advantage] may represent the end game for Medicare and unprecedented multiyear growth opportunity for managed care.” Berenson counsels that the overpayments to the private plans should be regarded as part of an ongoing “campaign to privatize Medicare without anyone noticing, without ever having to put the issue to a politically dangerous up or down vote, by using taxpayer money to advantage private plans and government regulation, paradoxically, to disadvantage” traditional Medicare fee-for-service.*

A study of Medicare Advantage conducted for the Commonwealth Fund also produced disturbing results. It found that “every [private] plan in *every county in the nation* was paid more in 2005 [the year the study covered] than its enrollees would have been expected to cost if they had been enrolled in traditional fee-for-service Medicare” (emphasis added).

The Commonwealth study noted that “the extra payments documented here represent a potential source of funds to at least partially offset the costs of improved benefits for all Medicare beneficiaries. These improvements could include filling in the coverage gap in the Medicare drug benefit or making other needed changes.” The study concluded that “The extra payments provided to Medicare Advantage plans distort the policy intent of the program, which was to provide an option for Medicare beneficiaries to enroll in private plans that could operate more efficiently than traditional Medicare fee-for-service plans. Moreover, the substantial cost of these extra payments, as well as the large number of pressing needs to which those resources might alternatively be applied, indicates that the current policy would bear careful re-examination.”**

Finally, the overpayments to private plans have drawn criticism from the Medicare Rights Center, a consumer advocate for Medicare beneficiaries. The Center recently wrote: “There are no standards for the extra benefits the private plans provide. There are no limits on the amount of subsidies the companies can keep as profit. There is no reporting back of how many ‘extra’ benefits were actually used by private plan members.” The Medicare Rights Center concludes that “a vague promise of extra benefits is no excuse for using scarce Medicare dollars.... There are much better ways for Medicare to use taxpayer money to help people with low-incomes afford their health care.”***

* Robert Berenson, “Doctoring Health Care, II,” *American Prospect*, January 7, 2007.

** Brian Biles *et al.*, “The Cost of Privatization: Extra Payments to Medicare Advantage Plans — Updated and Revised,” The Commonwealth Fund, November 2006.

*** Medicare Rights Center, “Asclepios,” March 22, 2007.

would bring enrollment in private plans back to about the same level as in 2006.²² This would occur because without the excess payments, the private plans would not offer the same additional benefits to attract enrollees.²³

²² These CBO estimates have been misinterpreted and misreported. CBO estimates that if this MedPAC recommendation is enacted, Medicare Advantage enrollment will be about 50 percent lower in 2012 (6.5 million

But this is hardly a sound basis for requiring the U.S. Treasury to continue making tens of billions of dollars of excessive payments to the private plans. If the chief concern really is to assist low-income and minority Medicare beneficiaries, then a more targeted, more effective, and less costly approach would be to expand and improve three existing programs within Medicaid (known collectively as the “Medicare Savings Programs”) that help low- and moderate-income Medicare beneficiaries to pay Medicare premiums and/or cost-sharing.

The three programs are the Qualified Medicare Beneficiary program (QMB), the Specified Low-Income Medicare Beneficiary program (SLMB), and the Qualifying Individual program (QI-1). QMB pays all Medicare premiums and cost-sharing for poor beneficiaries; the other two programs pay Medicare premiums (but not cost-sharing) for beneficiaries with incomes up to 135 percent of the poverty line.²⁴

Congress could expand these programs. For example, it could raise the programs’ income and/or resource limits.

MedPAC has suggested such an approach. It has noted that “if the justification for higher payments to [private] plans is that extra payments are being provided to low-income beneficiaries who choose such plans, there are less costly and more efficient ways to achieve this result,” such as improving the Medicare Savings Programs.²⁵ The low-income subsidy in the Medicare prescription drug program could be strengthened, as well.²⁶ Such improvements could readily be financed by using a portion of the savings secured by curbing the excessive overpayments to private plans. (MedPAC also notes that to ease the impact on Medicare Advantage enrollees who currently enjoy additional benefits, Congress could gradually phase in any curbs on private plan overpayments.)

Some of the savings from curtailing the excessive payments also could be used to expand health insurance coverage more generally. That would be particularly beneficial to low-income and minority individuals and families, since they are much more likely than other Americans to be uninsured.

beneficiaries) than the enrollment level projected for 2012 under the CBO baseline (12.5 million beneficiaries). It should be understood, however, that the baseline enrollment levels projected for 2012 are far above current enrollment levels, which stand at 8.2 million, because CBO assumes large annual increases in enrollment — primarily as a result of the overpayments.

In other words, CBO is *not* estimating that enactment of the MedPAC recommendation would cause a 50 percent reduction from the *current* level of Medicare Advantage enrollment by 2012. Rather, CBO estimates that enactment of this recommendation would avert the large future increases in enrollment that it projects, and would produce an enrollment level of 6.5 million in 2012, which would be about the same as the 2006 level (and about 20 percent below the 2007 enrollment level).

²³ Orszag, *op cit*.

²⁴ The overpayments to private plans also increase both federal *and* state costs related to the Medicare Savings Program programs, because these programs pay the costs for their low-income beneficiaries of the higher Medicare premiums that result from the overpayments.

Low-income Medicare beneficiaries who are eligible for full Medicaid (in general, those with incomes below 74 percent of the poverty line) also receive additional Medicaid benefits that Medicare does not cover.

²⁵ Miller, *op cit*.

²⁶ The Medicare Part D drug benefit includes a separate subsidy for low-income Medicare beneficiaries that pays for Part D premiums and/or Part D deductibles and cost-sharing.

The Most Egregious Excess: Private Fee-for-Service Plans

Defenders of the overpayments to private plans have argued that these overpayments help to ensure that private plans, particularly HMOs, offer more coordinated care than traditional Medicare fee-for-service. As a result, they claim, the private plans are better able to manage care for the most costly Medicare beneficiaries with chronic illnesses.*

This claim falls short in several respects. First, it is well documented that private plans generally serve Medicare beneficiaries who are healthier, on average, than those in traditional fee-for-service, rather than those in poorer health or those with chronic illnesses.

Second, private fee-for-service (PFFS) plans, an increasingly popular type of Medicare Advantage plan, offer little to no care coordination, despite racking up the largest overpayments. Originally established in 1997, PFFS plans are basically no different than traditional fee-for-service except that they are administered by private insurers rather than Medicare (and use a portion of their overpayments to offer some additional benefits to attract enrollment, like other private plans). Their growing popularity accounts for a large share of the Medicare Advantage enrollment increases over the last few years; 57 percent of all new participants in Medicare Advantage plans between 2005 and 2007 are people who enrolled in PFFS plans.** CBO expects that future increases in PFFS enrollment will account for about two-thirds of the large overall increases in private plan enrollment that CBO projects over the long term.***

Unlike HMOs and preferred-provider organizations (PPOs), however, PFFS plans do not coordinate care, establish provider networks, institute utilization review of health care services, have to offer a drug benefit, or have to meet various other standards required of other Medicare Advantage plans. As the Kaiser Family Foundation has noted, “much of the new enrollment into [Medicare Advantage] plans since implementation of Part D is not into plans that coordinate care....”***

CBO has pointed out that private plans can provide Medicare services at a lower cost than traditional fee-for-service only if they can achieve savings through lower utilization or reductions in provider payment rates that *more than offset* their significantly higher administrative costs, as well as their profits. Yet CBO notes that PFFS plans do not have to undertake such tasks: they do not have to establish networks or review utilization, and they generally do *not* pay providers less than traditional Medicare does. (Some PFFS plans may offer minimal care coordination such as employing counseling and monitoring patients by phone, according to CBO, but such modest activities are unlikely to have much impact on cost.) At the same time, CBO has explained, PFFS plans incur significantly higher administrative costs related to marketing activities aimed at the Medicare beneficiaries they seek to attract. (Some media accounts report marketing abuses by PFFS plans.***) Moreover, these plans have concentrated in those counties where the “payment benchmarks” used in setting Medicare payments to private plans are the highest relative to local fee-for-service costs.****

As noted, MedPAC has determined that private plans as a whole are paid an average of 12 percent more than traditional fee-for-service for comparable beneficiaries. PFFS plans, however, are overpaid to an even greater degree, receiving an average of 19 percent more than regular Medicare fee-for-service, according to MedPAC.**** In short, the PFFS plans that have been the main driver of recent increases in Medicare Advantage enrollment in recent years receive the largest overpayments of any type of Medicare Advantage plan, while generally offering no more care coordination than traditional fee-for-service.

* See, for example, “Statement in Support of Medicare Advantage,” Blue Cross and Blue Shield Association, March 21, 2007.

** Jonathan Blum, Ruth Brown and Miryam Frieder, “An Examination of Medicare Private Fee-for-Service Plans,” Kaiser Family Foundation, March 2007.

*** Peter Orszag, “The Medicare Advantage Program: Trends and Options,” Testimony before the Subcommittee on Health of the House Ways and Means Committee, Congressional Budget Office, March 21, 2007.

**** Miller, *op cit*.

For example, part of the savings could be used to help finance a substantial expansion of the State Children's Health Insurance Program (SCHIP), which Congress must reauthorize this year, and to improve enrollment among low-income children who are eligible for Medicaid and SCHIP but are not enrolled. Such steps could enable most low-income and minority uninsured children to obtain coverage.²⁷

This would be particularly beneficial for minorities, since about 62 percent of the nine million children who are uninsured are members of minority groups.²⁸ The Leadership Conference on Civil Rights and various other civil rights and religious organizations have called on Congress to provide \$60 billion over five years in additional funding for SCHIP and Medicaid as part of this year's SCHIP reauthorization legislation.²⁹ The budget resolutions that the Senate and the House have just adopted provide up to \$50 billion over five years for this purpose.

But to become a reality, this \$50 billion for expanded children's coverage will have to be "paid for." Without offsetting savings, the children's coverage expansions cannot move forward. Savings from adopting the MedPAC recommendations to curb excessive payments to private plans could provide some, perhaps most, of the offsetting savings needed. These savings could make possible a substantial improvement in children's coverage, especially among low-income and minority children.

Conclusion

Claims that low-income and minority Medicare beneficiaries rely heavily and disproportionately on private plans for supplemental coverage are not valid. Such claims rest on skewing the data by failing to count Medicaid or employer-based retiree coverage as supplemental coverage. Medicaid, not private plans, is the principal form of supplemental coverage for low-income and minority Medicare beneficiaries.

Nor does the claim that low-income and minority communities would be particularly hurt by reining in the Medicare overpayments stand up under scrutiny. Millions of minority beneficiaries who are *not* enrolled in the private plans are forced to pay higher Medicare premiums every month to subsidize the large overpayments the private plans receive. Curbing the overpayments would raise these people's disposable incomes. In addition, some of the savings from curbing the overpayments could be used to provide substantial, targeted help to low-income and minority individuals, both by strengthening the Medicare Savings Programs and by expanding health insurance coverage and reaching more uninsured children through SCHIP and Medicaid. Such a package of reforms financed by savings from curbing the overpayments would significantly benefit low-income and minority communities, not harm them.

²⁷ Edwin Park and Robert Greenstein, "Options Exist for Offsetting the Cost of Extending Health Coverage to More Low-Income Children," Center on Budget and Policy Priorities, March 8, 2007.

²⁸ Karyn Schwartz, Catherine Hoffman, and Allison Cook, "Health Insurance Coverage of America's Children," Kaiser Commission on Medicaid and the Uninsured, February 2007. These data are for 2005.

²⁹ See Letter to the Honorable John M. Spratt Jr. and the Honorable Paul D. Ryan, March 13, 2007, available at <http://www.civilrights.org/library/advocacy-letters/advocacy-letter-to-house.html>.